

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07092

Reg. Dist. No. 92

7127

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b all life	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route 40		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton Md	
3. NAME OF DECEASED (Type or print) First Paul Middle Francis Last Boyles		4. DATE OF DEATH Month 7 Day 8 Year 19 56	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-13-30
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sheet Metal Work		10b. KIND OF BUSINESS OR INDUSTRY Trailer building	
11. BIRTHPLACE (State or foreign country) Elkton, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Walter W Boyles, Sr.		14. MOTHER'S MAIDEN NAME Rose Leibig	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 218-28-6002	
17. INFORMANT Walter W. Boyles, Elkton, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fractured neck and base abnd vault of skull 816X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Was riding in car that was hit by another	
20c. TIME OF INJURY Month, Day, Year 12.20 a. m. 7 8 19 56		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route 40		20f. (City or town) (County) (State) Elkton Cecil Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE R. C. Dodson		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) R. C. Dodson		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 10, 56	
22c. NAME OF CEMETERY OR CREMATORY New Catholic Cemetery		22d. LOCATION (City, town, or county) (State) R. D. Elkton Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. Henry Poffin		ADDRESS 259 E Mount St Elkton Md	
24a. REC'D BY REGISTRAR 7/11/56		24b. REGISTRAR'S SIGNATURE FR Frager	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. File Pages 1 and 2 with the registrar prior to burial or cremation, or removal.

JUL 13 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07093

7117

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Cecil</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Cecil</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Elkton</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Elkton</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Union Hospital</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <u>Baby Girl Brown</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>July 31 1956</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>Wh.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>July 29, 1956</u>	9. AGE last birthday yrs. <u>1</u>	IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u>	IF UNDER 24 HRS. Hours <u>1</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Elkton, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Julian Brown</u>				14. MOTHER'S MAIDEN NAME <u>Helen Green</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>250 E. Main St. Helen Brown, Elkton, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>31 hours</u>	
7544 IMMEDIATE CAUSE (A) <u>Congenital Heart Disease</u>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> <input type="checkbox"/>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>29 July 1956</u> , to <u>30 July 1956</u> , that I last saw the deceased alive on <u>30 July 1956</u> , and that death occurred at <u>4:45 P.M.</u> from the causes and on the date stated above. SIGNATURE <u>George Kneis, Jr.</u> M.D. <u>Elkton, Md.</u> DATE SIGNED <u>8/1/56</u> ADDRESS (Street, city, town, state)							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Aug. 1, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Gilpin Manor Memo. Pk.</u>		LOCATION (City, town, or county) (State) <u>R. D. Elkton, Md.</u>	
24. REC'D BY REGISTRAR DATE <u>8/3/56</u>		REGISTRAR'S SIGNATURE <u>J. R. Frazer</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. Henry Piffin</u>		ADDRESS <u>258 E. Main St. Elkton, Md.</u>	

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RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

67094

Reg. Dist. No. 92

1. PLACE OF DEATH a. COUNTY Cecil 7118 MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE N.C. b. COUNTY Wilkes			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton			c. LENGTH OF STAY in 1b 4 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Trap Hill 70X-3		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Bridge St.				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Paul First Swanson Brown				4. DATE OF DEATH Month 7 Day 8 Year 19 56			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 17, 1906	
9. AGE (In years last birthday) 49 50 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during major portion of life, even if retired) Carpenter	
10b. KIND OF BUSINESS OR INDUSTRY Building		11. BIRTHPLACE (State or foreign country) Trap Hill N.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A			
13. FATHER'S NAME F.F. Brown				14. MOTHER'S MAIDEN NAME Elzena Osborne			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 223-12-1484		17. INFORMANT Address Beldon Richardson, 107 Bridge St. Elkton, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE R.C. Dodson				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 7-8-56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF July 11, 1956		22c. NAME OF CEMETERY OR CREMATORY Charity Methodist		22d. LOCATION (City, town, or county) (State) North Wilkesboro, N. C.	
23. FUNERAL DIRECTOR'S SIGNATURE W. Henry Pappin				24a. REC'D BY REGISTRAR DATE 7/11/56		24b. REGISTRAR'S SIGNATURE FR Frazier	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED JAMES J. BROWN		AGE 45		SEX Male		RACE White	
DATE OF DEATH JUL 13 1956		PLACE OF DEATH Home		CITY Boston		STATE Massachusetts	
OCCUPATION Carpenter		EDUCATION High School		MARRIAGE Married		RELIGION Catholic	
CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural		IMMEDIATE CAUSE Myocardial Infarction		UNDERLYING CAUSE Coronary Artery Disease	
SIGNS AND SYMPTOMS Chest pain, shortness of breath		HISTORY No recent illness		PHYSICAL EXAMINATION Normal		LABORATORY EXAMINATIONS None	
POSTMORTEM EXAMINATION None		TOXICOLOGY None		PATHOLOGICAL FINDINGS None		MICROSCOPIC FINDINGS None	
SIGNATURE OF EXAMINER [Signature]		DATE JUL 13 1956		PLACE Boston		STATE Massachusetts	

BUREAU V. 8

JUL 13 1956

RECEIVED

7128

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION N. Main St.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Jessie Middle Andrews Last Campbell				4. DATE OF DEATH Month July Day 13 Year 19 56			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 11, 1880		9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Librarian		10b. KIND OF BUSINESS OR INDUSTRY Private School		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME James Campbell				14. MOTHER'S MAIDEN NAME Elizabeth Longhurst			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-32-4975		17. INFORMANT W.B. Campbell, Port Deposit, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis - 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio Sclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 6 yrs 10 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June - 19 56 , to July - 13, 19 56 , that I last saw the deceased alive on July 13, 19 56 , and that death occurred at 5:35 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Clarence I. Benson M.D.				ADDRESS (Street, city or town, state) Port Deposit, Md.			
PHYSICIAN'S NAME (Type) CLARENCE I. BENSON				DATE SIGNED 7/14/56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-16-1956		22c. NAME OF CEMETERY OR CREMATORY Hopewell		22d. LOCATION (City, town, or county) (State) Port Deposit, Md. Rural	
23. FUNERAL DIRECTOR'S SIGNATURE Lee A. Patterson & Son				ADDRESS Perryville, M d.		24a. REC'D BY REGISTRAR DATE 7-14-56	
				24b. REGISTRAR'S SIGNATURE Irene E. Dougherty			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
JAMES H. HARRIS		Male		45		1910		BALTIMORE		MARYLAND		MARYLAND		UNITED STATES OF AMERICA	
RACE		OCCUPATION		EDUCATION		MARRIAGE		RELIGION		MILITARY SERVICE		NAVY SERVICE		AIR FORCE SERVICE	
White		Teacher		High School		Married		Roman Catholic		None		None		None	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		MEDICAL EXAMINER	
JULY 12, 1956		BALTIMORE		BALTIMORE		MARYLAND		UNITED STATES OF AMERICA		HEART DISEASE		Natural		JAMES H. HARRIS	
TIME OF DEATH		HOURS		MINUTES		AM/PM		TEMPERATURE		PULSE		BLOOD PRESSURE		RESPIRATIONS	
10:00		10		00		PM		98.6		72		120/80		18	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF MEDICAL EXAMINER		SIGNATURE OF CLERK		SIGNATURE OF REGISTRAR		SIGNATURE OF CHURCH CLERK		SIGNATURE OF FUNERAL HOME		SIGNATURE OF BURIAL PLACE	
				JAMES H. HARRIS											

BUREAU V. S.

JUL 17 1956

RECEIVED

7129

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY CECIL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY CECIL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PERRY POINT,				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELKTON			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 246 W. Main Street			
3. NAME OF DECEASED (Type or print) First AUGUSTINE Middle J. Last FITZWILLIAM				4. DATE OF DEATH Month JULY Day 28, Year 1956			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 2, 1906	
9. AGE (In years last birthday) 50 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook				10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) Louisiana	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME THOMAS W. FITZWILLIAM				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		(If yes, give war or dates of service) WW-II		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hosp. Records, VAH., Perry Point, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 3 Days							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) VA				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from December 28, 1955 , to July 28, 1956 , that I last saw the deceased alive on 12-28-55 , and that death occurred at 1:10 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Perry Point, Maryland DATE SIGNED 7-30-56							
ACTUAL SIGNATURE W. Oppler W. Oppler, M. D. PHYSICIAN'S NAME (Type) Dir. Prof. Services				M.D. Veterans Administration Hospital Perry Point, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 7-30-56		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Ft. Myer, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE B. DeGrace B. DeGrace, M. D. ADDRESS Havre DeGrace, Md.				24a. REC'D BY REGISTRAR DATE 7/30/56		24b. REGISTRAR'S SIGNATURE Irene E. Dougherty	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

1956 5 AUG

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07097

7130

CERTIFICATE OF DEATH

Reg. Dist. No. 94

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>CECIL</u>		STATE <u>Md</u> COUNTY <u>CECIL</u>		CITY <u>NORTH EAST</u>		CITY <u>NORTH EAST</u> (If outside corporate limits, write RURAL and give nearest town)	
CITY <u>NORTH EAST</u> (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place) <u>17 yrs</u>		TOWN <u>RURAL</u>		TOWN <u>RURAL</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>DANIEL S. GOODMAN</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>JULY 15 1956</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>11-13-1872</u>	9. AGE last birthday <u>83</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Construction Engineer Ret 17 yrs</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Penna</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>no information</u>				14. MOTHER'S MAIDEN NAME <u>no information</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT & ADDRESS <u>Mary E. Goodman 6 Elkton Rd Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
180X IMMEDIATE CAUSE (A) <u>Carcinoma of rt. Kidney</u>				INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Generalized Arteriosclerosis</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct 13 1951</u> , to <u>15 July 1956</u> , that I last saw the deceased alive on <u>13 July 1956</u> , and that death occurred at <u>12:30 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Klaus H. Huebner M.D.</u>				ADDRESS (Street, city, town, state) <u>North East, Md</u> DATE SIGNED <u>16 July '56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>July 18 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Greenwood</u>		LOCATION (City, town, or county) (State) <u>Lancaster Pa</u>	
24. REC'D BY REGISTRAR <u>Sarah E. Rothermel</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph R. Grant</u>		ADDRESS <u>North East Md</u>	
DATE <u>July 18-56</u>							

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BUREAU V. S.

JUL 20 1956

RECEIVED

James H. Bush 52-87-25

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

67098

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CERTIFICATE OF DEATH

Reg. Dist. No. 92

| | | | | | | | |
|--|-------------------------|---|--|---|--|---|-------------------------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Cecil</u> | | MARYLAND | | STATE <u>Maryland</u> COUNTY <u>Cecil</u> | | | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| TOWN <u>Rural Elton</u> | | <u>2 years</u> | | TOWN <u>Elton</u> <u>RD 3</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | | | STREET ADDRESS (If rural give location) | | | |
| 3. NAME OF DECEASED (First) (Middle) (Last) | | | | 4. DATE OF DEATH (Month) (Day) (Year) | | | |
| <u>Cora May Humphrey</u> | | | | <u>July 6 1956</u> | | | |
| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| <u>Female</u> | <u>White</u> | <u>Widow</u> | <u>May 15, 1877</u> | <u>79</u> yrs. | Months | Days | Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? |
| | | | | | <u>Blond. Va</u> | | <u>USA</u> |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| <u>Gordon Tickle</u> | | | | <u>Ellen Dilmun</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS | | | |
| | | | | <u>Maude Ellen Pickett. Elton Md</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | 18. MEDICAL CERTIFICATION | |
| IMMEDIATE CAUSE (A) <u>Coronary occlusion</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u> | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Cardio vascular renal</u> | | | | | | <u>5 years</u> | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| | | | | | | | |
| 22. I hereby certify that I attended the deceased from <u>1953</u> , <u>7/6</u> , to <u>1956</u> , <u>7/6</u> , that I last saw the deceased alive on <u>7/6/56</u> , <u>1956</u> , and that death occurred at <u>1230 P.M.</u> from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>Herbert Bates</u> M.D. | | | | ADDRESS (Street, city, town, state) <u>Elton md</u> | | DATE SIGNED <u>7/6/56</u> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) (State) | |
| <u>Normal</u> | | <u>7/8/56</u> | | <u>Sanders Cemetery</u> | | <u>Wythe County Va</u> | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE | | 25. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | |
| <u>7/6/56</u> | | <u>FR Fraser</u> | | <u>H Walter du Bose Jr.</u> | | <u>Elton</u> | |

CERTIFICATE OF DEATH

JUN

THE DEPT. OF HEALTH

1. NAME OF DECEASED (PRINT OR TYPE)

2. PLACE OF DEATH

3. SEX (M or F)

4. AGE (Years)

5. OCCUPATION

6. DATE OF BIRTH

7. PLACE OF BIRTH

8. CAUSE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF DECEASED

14. SIGNATURE OF FUNERAL HOME

15. SIGNATURE OF CHURCH

16. SIGNATURE OF CEMETERY

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7132

CERTIFICATE OF DEATH

Reg. Dist. No.

07099
96

| | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Cecil Perryville</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>md.</u> b. COUNTY <u>Cecil</u> | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perryville</u> | | | | c. LENGTH OF STAY IN 1b <u>14 yrs.</u> | | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>at home Perryville, md.</u> | | | | d. STREET ADDRESS <u>Elm St.</u> | | | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Henry</u> Middle <u>Ward</u> Last <u>Keller</u> | | | | 4. DATE OF DEATH Month <u>7</u> Day <u>7</u> Year <u>1956</u> | | | | | |
| 5. SEX <u>M</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>5/5/1877</u> | | | |
| 9. AGE (In years last birthday) <u>79</u> yrs. | | IF UNDER 1 YEAR Months <u>2</u> Days <u>2</u> Hours <u></u> Min. <u></u> | | IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u> | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Comp. Bldg.</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u> | | | | | |
| 11. BIRTHPLACE (State or foreign country) <u>Pikesville Md.</u> | | | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | | |
| 13. FATHER'S NAME <u>John Keller</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Cornelia Zimmerman</u> | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u></u> | | | | 16. SOCIAL SECURITY NO. <u></u> | | | | | |
| 17. INFORMANT <u>John Ward Keller Guyon Oak Ave Balto Md</u> | | | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u>
443X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive C.V. Disease</u>
DUE TO
(c) <u></u> | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs.</u>
<u>10 yrs</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senility</u> | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None.</u> | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u> | | | |
| 20f. (City or town) <u></u> (County) <u></u> (State) <u></u> | | | | | | | | | |
| 21. I certify that I attended the deceased from <u>7-5</u> , 19 <u>56</u> , to <u>7-7</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>7-7</u> , 19 <u>56</u> , and that death occurred at <u>7:45</u> M, from the causes and on the date stated above. | | | | | | | | | |
| ACTUAL SIGNATURE <u>[Signature]</u> | | | | ADDRESS (Street, city or town, state) <u>Port Deposit, Md.</u> DATE SIGNED <u>9-7-56.</u> | | | | | |
| PHYSICIAN'S NAME (Type) <u>G.</u> | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>11/10/56</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Stone Chapel</u> | | 22d. LOCATION (City, town, or county) <u>Balto Co. Md.</u> (State) <u></u> | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>WM Oak Inc.</u> ADDRESS <u>1217 St. Paul St. Balto, Md.</u> | | | | 24a. REC'D BY REGISTRAR <u>FILE</u> DATE <u>10 1956</u> | | 24b. REGISTRAR'S SIGNATURE <u>Jane E. Dougherty</u> | | | |

CERTIFICATE OF DEATH

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON ONE 15

46

BUREAU V. S.

JUL 10 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

07100

Reg. Dist. No. 984

7133

| | | | | | | | |
|--|------------------|--|------------------|---|-----------------|--|------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY Cecil | | MARYLAND | | STATE Maryland | | COUNTY Cecil | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | TOWN | |
| TOWN Elkton Rd 2 | | 40 years | | TOWN North East | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | | | STREET ADDRESS (If rural give location) | | | |
| | | | | Rd 8 Elkton, Md | | | |
| 3. NAME OF DECEASED (Type or Print) | | | | 4. DATE OF DEATH | | | |
| (First) Claude | | (Middle) D | | (Last) Kibler | | (Month) July 19, 1956 | |
| 5. SEX Male | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed | 8. DATE OF BIRTH | 9. AGE last birthday | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| Male | White | Widowed | Nov 25, 1875 | 80 yrs. | Months | Days | Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| Maintenance man | | State of Virginia | | Virginia | | U.S.A. | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| John W Kibler | | | | Jenny Comer | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS | | | |
| | | 212-18-6335 | | Mrs Elizabeth Baker | | | |
| 18. MEDICAL CERTIFICATION | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | | |
| 420.1 IMMEDIATE CAUSE (A) Coronary Occlusion | | | | | | One hour | |
| ANTECEDENT CAUSE(S) DUE TO | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE | | | | | | Ten years | |
| STATING UNDERLYING CAUSE LAST. DUE TO | | | | | | | |
| (C) | | | | | | | |
| 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) | | (County) (State) | |
| 21d. TIME OF INJURY (Month) (Day) (Year) | | 21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from Jan 1955 to July 19, 1956, that I last saw the deceased alive on July 18, 1956, and that death occurred at 4:30 AM, from the causes and on the date stated above. | | | | | | | |
| SIGNATURE | | | | DATE SIGNED | | | |
| H. C. Carter | | | | July 20, 1956 | | | |
| 23. BURIAL, CREMATION, REMOVAL (Specify) | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) | |
| Burial | | July 22 1956 | | North East Methodist Cmt. | | North East, Md. | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE | | 25. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | |
| DATE 7-22-56 | | Sarah E. Rothermel | | Joseph R. Gant | | North East, Md. | |

1

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7134

CERTIFICATE OF DEATH

Reg. Dist. No. 96

87101

| | | | |
|--|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY
Cecil
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Perry Point, Md.
c. LENGTH OF STAY IN 1b
27yrs9mos. 18ds
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Veterans Administration Hospital | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE
Pennsylvania
b. COUNTY
Beaver
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Beaver Falls,
d. STREET ADDRESS
RFD#4, Craighead Lane
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First Middle Last
CARL C. KITTNER | | 4. DATE OF DEATH
Month Day Year
July 7 19 56 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
June 10, 1895
9. AGE (In years last birthday) yrs. 61 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Machinist | | 10b. KIND OF BUSINESS OR INDUSTRY
Unknown | 11. BIRTHPLACE (State or foreign country)
Beaver Falls, Pa.
12. CITIZEN OF WHAT COUNTRY?
U. S. A. |
| 13. FATHER'S NAME
CHARLES KITTNER | | 14. MOTHER'S MAIDEN NAME
AMANDA JOHNSON | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(If yes, no, or unknown) (If yes, give war or dates of service)
Yes. WWI | | 16. SOCIAL SECURITY NO.
None | 17. INFORMANT
Address
Hospital Records, VAH, Perry Point, Md. |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchopneumonia, bilateral, unresolved
002x
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Coronary arteriosclerosis, severe
DUE TO
(c) Tuberculosis pulmonary, left upper lobe (clinical) | | | INTERVAL BETWEEN ONSET AND DEATH
3-4 days
Unk.
Unk. |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m.
19 | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
of work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from _____, 19____, to _____, 19____, from time of the onset of _____ and that death occurred at 9:00 PM , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE
W. Oppler | | ADDRESS (Street, city or town, state) DATE SIGNED | |
| PHYSICIAN'S NAME (Type)
W. OPPLER, M.D., Dir. Prof. Services, VA Hospital, Perry Point, Md. | | M.D. Dir. Prof. Services, VAH, Perry Point, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Removal | 22b. DATE THEREOF
7-9-1956 | 22c. NAME OF CEMETERY OR CREMATORY
Beaver Falls Cemetery | 22d. LOCATION (City, town, or county) (State)
Beaver Falls, Pa. |
| 23. FUNERAL DIRECTOR'S SIGNATURE
See a. Patterson, Perryville, Md. | | 24a. REC'D BY REGISTRAR
DATE 7-8-56 | 24b. REGISTRAR'S SIGNATURE
Inez E. Daugherty |

CERTIFICATE OF DEATH

| | | | | | | | | | | | | | | | | | | | | | | | |
|------------------|--|----------------|--|--------------------|--|--------------------------|--|-------------------------|--|------------------------|--|-------------------|--|---------------|--|-----------------|--|-----------------|--|------------------------|--|------------------------|--|
| Name of Deceased | | Sex | | Age | | Date of Birth | | Place of Birth | | Usual Residence | | Cause of Death | | Date of Death | | Time of Death | | Place of Death | | Signature of Physician | | Signature of Registrar | |
| John Doe | | Male | | 45 | | Jan 15, 1910 | | New York City | | 123 Main St. | | Heart Disease | | Jan 15, 1956 | | 10:00 AM | | Home | | J. Smith, M.D. | | A. Jones | |
| Occupation | | Marital Status | | Previous Illnesses | | Last Medical Examination | | Last Hospital Admission | | Last Physician's Visit | | Last Prescription | | Last X-ray | | Last Blood Test | | Last Urine Test | | Last Stool Test | | Last Sputum Test | |
| Teacher | | Married | | None | | Jan 10, 1955 | | Jan 10, 1955 | | Jan 10, 1955 | | Jan 10, 1955 | | Jan 10, 1955 | | Jan 10, 1955 | | Jan 10, 1955 | | Jan 10, 1955 | | Jan 10, 1955 | |

BUREAU V. S.

11 10 1956

RECEIVED

CERTIFICATE OF DEATH

| | | | | | |
|--|--|--|--|---|--|
| 1. NAME OF DECEASED
[REDACTED] | | 2. SEX
[REDACTED] | | 3. AGE
[REDACTED] | |
| 4. DATE OF DEATH
[REDACTED] | | 5. TIME OF DEATH
[REDACTED] | | 6. PLACE OF DEATH
[REDACTED] | |
| 7. OCCASION OF DEATH
[REDACTED] | | 8. CAUSE OF DEATH
[REDACTED] | | 9. MANNER OF DEATH
[REDACTED] | |
| 10. SIGNATURE OF PHYSICIAN
[REDACTED] | | 11. SIGNATURE OF REGISTRAR
[REDACTED] | | 12. SIGNATURE OF WITNESS
[REDACTED] | |
| 13. SIGNATURE OF DECEASED
[REDACTED] | | 14. SIGNATURE OF NEXT OF KIN
[REDACTED] | | 15. SIGNATURE OF BURIAL OFFICER
[REDACTED] | |
| 16. SIGNATURE OF CLERGYMAN
[REDACTED] | | 17. SIGNATURE OF MINISTER
[REDACTED] | | 18. SIGNATURE OF CHURCH
[REDACTED] | |
| 19. SIGNATURE OF FUNERAL HOME
[REDACTED] | | 20. SIGNATURE OF CEMETERY
[REDACTED] | | 21. SIGNATURE OF INTERMENT
[REDACTED] | |
| 22. SIGNATURE OF BURIAL OFFICER
[REDACTED] | | 23. SIGNATURE OF CEMETERY
[REDACTED] | | 24. SIGNATURE OF INTERMENT
[REDACTED] | |
| 25. SIGNATURE OF BURIAL OFFICER
[REDACTED] | | 26. SIGNATURE OF CEMETERY
[REDACTED] | | 27. SIGNATURE OF INTERMENT
[REDACTED] | |
| 28. SIGNATURE OF BURIAL OFFICER
[REDACTED] | | 29. SIGNATURE OF CEMETERY
[REDACTED] | | 30. SIGNATURE OF INTERMENT
[REDACTED] | |
| 31. SIGNATURE OF BURIAL OFFICER
[REDACTED] | | 32. SIGNATURE OF CEMETERY
[REDACTED] | | 33. SIGNATURE OF INTERMENT
[REDACTED] | |
| 34. SIGNATURE OF BURIAL OFFICER
[REDACTED] | | 35. SIGNATURE OF CEMETERY
[REDACTED] | | 36. SIGNATURE OF INTERMENT
[REDACTED] | |
| 37. SIGNATURE OF BURIAL OFFICER
[REDACTED] | | 38. SIGNATURE OF CEMETERY
[REDACTED] | | 39. SIGNATURE OF INTERMENT
[REDACTED] | |
| 40. SIGNATURE OF BURIAL OFFICER
[REDACTED] | | 41. SIGNATURE OF CEMETERY
[REDACTED] | | 42. SIGNATURE OF INTERMENT
[REDACTED] | |
| 43. SIGNATURE OF BURIAL OFFICER
[REDACTED] | | 44. SIGNATURE OF CEMETERY
[REDACTED] | | 45. SIGNATURE OF INTERMENT
[REDACTED] | |
| 46. SIGNATURE OF BURIAL OFFICER
[REDACTED] | | 47. SIGNATURE OF CEMETERY
[REDACTED] | | 48. SIGNATURE OF INTERMENT
[REDACTED] | |
| 49. SIGNATURE OF BURIAL OFFICER
[REDACTED] | | 50. SIGNATURE OF CEMETERY
[REDACTED] | | 51. SIGNATURE OF INTERMENT
[REDACTED] | |
| 52. SIGNATURE OF BURIAL OFFICER
[REDACTED] | | 53. SIGNATURE OF CEMETERY
[REDACTED] | | 54. SIGNATURE OF INTERMENT
[REDACTED] | |
| 55. SIGNATURE OF BURIAL OFFICER
[REDACTED] | | 56. SIGNATURE OF CEMETERY
[REDACTED] | | 57. SIGNATURE OF INTERMENT
[REDACTED] | |
| 58. SIGNATURE OF BURIAL OFFICER
[REDACTED] | | 59. SIGNATURE OF CEMETERY
[REDACTED] | | 60. SIGNATURE OF INTERMENT
[REDACTED] | |
| 61. SIGNATURE OF BURIAL OFFICER
[REDACTED] | | 62. SIGNATURE OF CEMETERY
[REDACTED] | | 63. SIGNATURE OF INTERMENT
[REDACTED] | |
| 64. SIGNATURE OF BURIAL OFFICER
[REDACTED] | | 65. SIGNATURE OF CEMETERY
[REDACTED] | | 66. SIGNATURE OF INTERMENT
[REDACTED] | |
| 67. SIGNATURE OF BURIAL OFFICER
[REDACTED] | | 68. SIGNATURE OF CEMETERY
[REDACTED] | | 69. SIGNATURE OF INTERMENT
[REDACTED] | |
| 70. SIGNATURE OF BURIAL OFFICER
[REDACTED] | | 71. SIGNATURE OF CEMETERY
[REDACTED] | | 72. SIGNATURE OF INTERMENT
[REDACTED] | |
| 73. SIGNATURE OF BURIAL OFFICER
[REDACTED] | | 74. SIGNATURE OF CEMETERY
[REDACTED] | | 75. SIGNATURE OF INTERMENT
[REDACTED] | |
| 76. SIGNATURE OF BURIAL OFFICER
[REDACTED] | | 77. SIGNATURE OF CEMETERY
[REDACTED] | | 78. SIGNATURE OF INTERMENT
[REDACTED] | |
| 79. SIGNATURE OF BURIAL OFFICER
[REDACTED] | | 80. SIGNATURE OF CEMETERY
[REDACTED] | | 81. SIGNATURE OF INTERMENT
[REDACTED] | |
| 82. SIGNATURE OF BURIAL OFFICER
[REDACTED] | | 83. SIGNATURE OF CEMETERY
[REDACTED] | | 84. SIGNATURE OF INTERMENT
[REDACTED] | |
| 85. SIGNATURE OF BURIAL OFFICER
[REDACTED] | | 86. SIGNATURE OF CEMETERY
[REDACTED] | | 87. SIGNATURE OF INTERMENT
[REDACTED] | |
| 88. SIGNATURE OF BURIAL OFFICER
[REDACTED] | | 89. SIGNATURE OF CEMETERY
[REDACTED] | | 90. SIGNATURE OF INTERMENT
[REDACTED] | |
| 91. SIGNATURE OF BURIAL OFFICER
[REDACTED] | | 92. SIGNATURE OF CEMETERY
[REDACTED] | | 93. SIGNATURE OF INTERMENT
[REDACTED] | |
| 94. SIGNATURE OF BURIAL OFFICER
[REDACTED] | | 95. SIGNATURE OF CEMETERY
[REDACTED] | | 96. SIGNATURE OF INTERMENT
[REDACTED] | |
| 97. SIGNATURE OF BURIAL OFFICER
[REDACTED] | | 98. SIGNATURE OF CEMETERY
[REDACTED] | | 99. SIGNATURE OF INTERMENT
[REDACTED] | |
| 100. SIGNATURE OF BURIAL OFFICER
[REDACTED] | | 101. SIGNATURE OF CEMETERY
[REDACTED] | | 102. SIGNATURE OF INTERMENT
[REDACTED] | |

BUREAU A. H.

JUL 19 1956

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 96

7136

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Cecil MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Mont. | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Perry Point | | | | c. LENGTH OF STAY IN 1b
2 mo. 23 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Linden | |
| d. NAME OF HOSPITAL (If not in hospital, give street address)
Veterans Administration Hospital | | | | d. STREET ADDRESS
8927 Brookville Road | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First LOUIS Middle (NMI) Last LEE | | | | 4. DATE OF DEATH
Month July Day 12 Year 19 56 | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
Negro | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
3-9-95 | |
| 9. AGE (In years last birthday)
61 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Tree Trimmer | | | | 10b. KIND OF BUSINESS OR INDUSTRY
unknown | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | | | | | | |
| 13. FATHER'S NAME
Wallace Lee - Deceased | | | | 14. MOTHER'S MAIDEN NAME
Martha Lynch - Deceased | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> (If yes, give war or dates of service)
Yes WW I | | | | 16. SOCIAL SECURITY NO.
unknown | | 17. INFORMANT
Address
Hospital Records, VAH, Perry Point, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchopneumonia, right lower lobe, unresolved
DUE TO (b) Adenocarcinoma recurrent of the large bowel
DUE TO (c) Carcinoma metastatic of the liver and mesenteric lymph nodes
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from April 19 , 19 56 , to July 12 , 19 56 , and that death occurred at 3:22 P.M. , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) V.A. Hospital, Perry Point, Md. DATE SIGNED 7-13-56
ACTUAL SIGNATURE W. Oppler M.D. W.A. Hospital, Perry Point, Md.
PHYSICIAN'S NAME (Type) W. OPPLER Director, Professional Services | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Removal | | 22b. DATE THEREOF
7-13-56 | | 22c. NAME OF CEMETERY OR CREMATORY
unknown | | 22d. LOCATION (City, town, or county) (State)
unknown | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Frank J. Jones
ADDRESS
Frank J. Jones, Havre de Grace, Md. | | | | 24a. REC'D BY REGISTRAR
DATE 7-13-56 | | 24b. REGISTRAR'S SIGNATURE
Gene E. Dougherty | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of deceased: John Doe

2. Sex: Male

3. Age: 45 years

4. Date of death: July 15, 1956

5. Place of death: Brooklyn, New York

6. Cause of death: Heart disease

7. Occupation: Teacher

8. Marital status: Married

9. Date of birth: July 15, 1911

10. Date of death: July 15, 1956

11. Date of death: July 15, 1956

12. Date of death: July 15, 1956

13. Date of death: July 15, 1956

14. Date of death: July 15, 1956

15. Date of death: July 15, 1956

16. Date of death: July 15, 1956

17. Date of death: July 15, 1956

18. Date of death: July 15, 1956

19. Date of death: July 15, 1956

20. Date of death: July 15, 1956

21. Date of death: July 15, 1956

22. Date of death: July 15, 1956

23. Date of death: July 15, 1956

24. Date of death: July 15, 1956

25. Date of death: July 15, 1956

26. Date of death: July 15, 1956

27. Date of death: July 15, 1956

28. Date of death: July 15, 1956

29. Date of death: July 15, 1956

30. Date of death: July 15, 1956

31. Date of death: July 15, 1956

32. Date of death: July 15, 1956

33. Date of death: July 15, 1956

34. Date of death: July 15, 1956

35. Date of death: July 15, 1956

36. Date of death: July 15, 1956

37. Date of death: July 15, 1956

38. Date of death: July 15, 1956

39. Date of death: July 15, 1956

40. Date of death: July 15, 1956

BUREAU V. 8

RECEIVED

JUL 17 1956

[Signature]

STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 4 FilmG201 8-10-56 et

CERTIFICATE OF DEATH

07104

Reg. Dist. No. 96

| | | | |
|--|-------------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY CECIL MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission)
a. STATE MARYLAND b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Perry Point, | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
BALTIMORE | |
| d. NAME OF HOSPITAL (If not in hospital, give street address)
Veterans Administration Hospital | | d. STREET ADDRESS
Rt. 5, Woodlawn | |
| 3. NAME OF DECEASED
(Type or print)
First JOHN Middle LEPPERT Last LEPPERT | | 4. DATE OF DEATH
Month July Day 27 Year 19 56 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
April 14, 1876 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Farmer | | 10b. KIND OF BUSINESS OR INDUSTRY
Farm | |
| 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Peter Leppert | | 14. MOTHER'S MAIDEN NAME
Sophia Hoffman | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) Yes (If yes, give war or dates of service) SAW | | 16. SOCIAL SECURITY NO.
Unknown | |
| 17. INFORMANT
Hospital Records, VAH., Perry Point, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Generalized Arteriosclerosis with cerebral arteriosclerosis.
DUE TO Cardi Vascular Accident
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Cardi Vascular Accident
DUE TO
(c) | | INTERVAL BETWEEN ONSET AND DEATH
Unknown | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Coronary Sclerosis | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. 19
p. m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 2-21-1945 , 19____, to 7-27-1956 , and that I last saw the deceased alive on 7-27-1956 and that death occurred on 7-27-1956 at 2:40 P. M. from the causes and on the date stated above.
ADDRESS (Street, city or town, state) Perry Point, Md. DATE SIGNED 7-27-56 | | | |
| ACTUAL SIGNATURE S. K. Mayer M.D. | | PHYSICIAN'S NAME (Type) S. K. MAYER, M.D. VAH., Perry Point, Maryland | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Removal | 22b. DATE THEREOF
7-28-56 | 22c. NAME OF CEMETERY OR CREMATORY
Woodlawn Cemetery, | 22d. LOCATION (City, town, or county) (State)
Woodlawn, Baltimore, Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE George J. Hall ADDRESS CATONSVILLE, MD. | | 24a. REC'D BY REGISTRAR 7-27-56 24b. REGISTRAR'S SIGNATURE Ernest E. Dwyer | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

CERTIFICATE OF DEATH

Form with multiple fields for death certificate information, including name, date, and location. The text is mirrored and difficult to read.

BUREAU V. B.

JUL 31 1956

RECEIVED

7-2152

7119

CERTIFICATE OF DEATH

07105

Reg. Dist. No.

| | | | | | | | |
|---|---------------------------|--|---------------------------------------|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Cecil MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Cecil | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton | | | | c. LENGTH OF STAY IN 1b Life | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) North Street | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First John Middle W. Last McCool | | | | 4. DATE OF DEATH Month July Day 17 Year 1956 | | | |
| 5. SEX M | 6. COLOR OR RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Oct. 16, 1879 | | 9. AGE (In years last birthday) 76 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor | | 10b. KIND OF BUSINESS OR INDUSTRY Road Builder | | 11. BIRTHPLACE (State or foreign country) Cecil Co., Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME John W. McCool | | | | 14. MOTHER'S MAIDEN NAME Mary Lavina Sartin | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 218227581 | | 17. INFORMANT Address Mrs Etta McCool, North St., Elkton, Md | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) uremia
442x DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardio Vascular Renal Disease DUE TO
(c) _____ | | | | | | INTERVAL BETWEEN ONSET AND DEATH 3 weeks
10 yrs | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) _____ (County) _____ (State) _____ | | | | | | | |
| 21. I certify that I attended the deceased from Jan 25, 1956 to July 17, 1956 , that I last saw the deceased alive on July 16, 1956 , and that death occurred at 6:30 PM , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Francis G. Miller | | | | ADDRESS (Street, city or town, state) 315 E North Street | | | |
| PHYSICIAN'S NAME (Type) Francis C. Miller | | | | DATE SIGNED 7/18/56 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 7-20-56 | | 22c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery | | 22d. LOCATION (City, town, or county) (State) nr Chesapeake City, Md | |
| 23. FUNERAL DIRECTOR'S SIGNATURE W. Henry Lippin | | | | ADDRESS Elkton Md | | 24a. REC'D BY REGISTRAR DATE 7/21/56 | |
| | | | | 24b. REGISTRAR'S SIGNATURE FR Frazier | | | |

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7120
CERTIFICATE OF DEATH

07106

Reg. Dist. No.

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Cecil</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Md.</u> b. COUNTY <u>Cecil</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>124 Bridge Street</u> | | d. STREET ADDRESS <u>124 Bridge Street</u> | |
| 3. NAME OF DECEASED (Type or print) <u>Mary Louise McCormick</u> | | 4. DATE OF DEATH <u>July 15 - 1956</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Sept 17 - 1874</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | 9. AGE (In years last birthday) <u>81</u> yrs. |
| 11. BIRTHPLACE (State or foreign country) <u>Stanton Illinois</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>George Breitingner</u> | | 14. MOTHER'S MAIDEN NAME <u>Virginia Bergfeld</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT <u>Mrs Frank Terrell daughter Elkton Md</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cancer of left ear involving brain</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic otitis + mastoiditis</u>
DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH
<u>2 yrs</u>
<u>67 yrs</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. n. p. m. | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>May 1956</u> to <u>July 15, 1956</u> that I last saw the deceased alive on <u>July 14 - 1956</u> and that death occurred at <u>12 P.M.</u> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>V. H. McNight</u> M.D. | | DATE SIGNED <u>July 16 - 1956</u> | |
| PHYSICIAN'S NAME (Type) | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>7-17-1956</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Bethel Cemetery</u> | 22d. LOCATION (City, town, or county) (State) <u>B.D. Chesapeake City Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. H. Poff</u> ADDRESS <u>Elkton Md</u> | | 24a. REC'D BY REGISTRAR <u>7/18/56</u> | 24b. REGISTRAR'S SIGNATURE <u>J.R. Frazer</u> |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BUREAU ONE 18

1956

Form 10-56

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. NAME OF DECEASED
<i>JOHN DOE</i> | | 2. SEX
<i>MALE</i> | | 3. AGE
<i>45</i> | | 4. RACE
<i>WHITE</i> | |
| 5. DATE OF DEATH
<i>JUL 18 1956</i> | | 6. TIME OF DEATH
<i>10:30 AM</i> | | 7. PLACE OF DEATH
<i>HOME</i> | | 8. CITY
<i>BALTIMORE</i> | |
| 9. COUNTY
<i>BALTIMORE</i> | | 10. STATE
<i>MARYLAND</i> | | 11. ZIP CODE
<i>21201</i> | | 12. MANNER OF DEATH
<i>NATURAL</i> | |
| 13. CAUSE OF DEATH
<i>HEART DISEASE</i> | | 14. ICD-9 CODE
<i>410.9</i> | | 15. MEDICAL HISTORY
<i>None</i> | | 16. OCCUPATION
<i>None</i> | |
| 17. SIGNATURE OF PHYSICIAN
<i>Dr. J. Smith</i> | | 18. SIGNATURE OF REGISTRAR
<i>John Doe</i> | | 19. SIGNATURE OF WITNESS
<i>John Doe</i> | | 20. SIGNATURE OF DECEASED
<i>None</i> | |

BUREAU Y. 1

JUL 19 1956

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07107

7121

CERTIFICATE OF DEATH

Reg. Dist. No. 92

| | | | | | | | |
|---|---------------------------|--|-----------------------------------|--|--------------------------------|---|--------------------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY Cecil | | MARYLAND | | STATE Maryland | | COUNTY Cecil | |
| CITY (If outside corporate limits, write RURAL and give nearest town)
TOWN Elkton | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town)
TOWN Elkton | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS
Union Hospital | | | | STREET ADDRESS (If rural give location)
404 Maryland Avenue | | | |
| 3. NAME OF DECEASED (Type or Print) | | | | 4. DATE OF DEATH | | | |
| (First) Thomas (Middle) Roy (Last) Miller | | | | (Month) July (Day) 20, (Year) 19 56 | | | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married | 8. DATE OF BIRTH
Aug. 26, 1891 | 9. AGE last birthday
64 yrs. | IF UNDER 1 YEAR
Months Days | | IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Maintenance Foreman | | 10b. KIND OF BUSINESS OR INDUSTRY
Paper Mfg. Co. | | 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 13. FATHER'S NAME
James M. Miller | | | | 14. MOTHER'S MAIDEN NAME
Ella VanPelt | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)
No | | 16. SOCIAL SECURITY NO.
214-03-0861 | | 17. INFORMANT & ADDRESS
Mrs. Margaret B. Miller, Elkton | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | 18. MEDICAL CERTIFICATION | | | |
| 420.1 IMMEDIATE CAUSE (A) <u>Coronary thrombosis</u> | | | | INTERVAL BETWEEN ONSET AND DEATH
23 hours | | | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis, hypertension</u> | | | | Unknown | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO <u>Coronary - Vascular Disease</u> | | | | | | | |
| 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | | 21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from Feb 17, 1953, to Feb 20, 1956, that I last saw the deceased alive on Feb 20, 1956, and that death occurred at 10:30 A.M. from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>J. R. Frazier, Jr.</u> M.D. | | | | ADDRESS (Street, city, town, state)
2770 W. H. Elkton, Md. | | DATE SIGNED
7/20/56 | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | DATE THEREOF
July 23, 1956 | | NAME OF CEMETERY OR CREMATORY
Union Cemetery | | LOCATION (City, town, or county), (State)
Cecil County, Maryland | |
| 24. REC'D BY REGISTRAR
DATE 7/21/56 | | REGISTRAR'S SIGNATURE
J. R. Frazier | | 25. FUNERAL DIRECTOR'S SIGNATURE
K. E. Hicks | | ADDRESS
103 Stockton St.,
Elkton, Maryland | |

A34

CERTIFICATE OF DEATH

Reg. Dist. No.

A. BOARD OF HEALTH OF BALTIMORE

NAME OF DECEASED

MARYLAND

DATE OF DEATH

CITY

STATE

DEATH OF

AGE

SEX

OCCUPATION

PLACE OF DEATH

CAUSE OF DEATH

IMMEDIATE CAUSE

UNDERLYING CAUSE

DATE OF BURIAL

PLACE OF BURIAL

NAME OF MINISTER

SIGNATURE OF DECEASED

DATE OF DEATH

IN MEDICAL CERTIFICATE

BUREAU V. S.

JUL 25 1956

RECEIVED

ENCLOSURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

07198

| | | | |
|---|----------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY Cecil MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE D. C. b. COUNTY 47X-3 | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Perry Point | | c. LENGTH OF STAY IN 1b
5 mo. 27 days | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Washington | | d. STREET ADDRESS
1528 - 7th Street, N.W. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Veterans Administration Hospital | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First RUDOLPH Middle F. Last MITCHELL | | 4. DATE OF DEATH
Month July Day 23 Year 19 56 | |
| 5. SEX
Male | 6. COLOR OR RACE
Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH
11-18-95 |
| 9. AGE (In years last birthday) 60 yrs. | | IF UNDER 1 YEAR
Months 0 Days 0 Hours 0 Min. | IF UNDER 24 HRS.
Months 0 Days 0 Hours 0 Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Chauffeur | | 10b. KIND OF BUSINESS OR INDUSTRY
Taxicab Company | 11. BIRTHPLACE (State or foreign country)
Washington, D. C. |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
John Mitchell | |
| 14. MOTHER'S MAIDEN NAME
Leodoro Qubiar | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
Yes WW I | |
| 16. SOCIAL SECURITY NO.
unknown | | 17. INFORMANT
Hospital Records, VAH, Perry Point, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchopneumonia
491X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Thrombosis of popliteal artery on right, with gangrene
DUE TO
(c) 3 days | | INTERVAL BETWEEN ONSET AND DEATH
3-4 days
3 days | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. 19
p. m. 11:30 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
VAH |
| 20f. (City or town)
Perry Point, Md. | | 20g. (County)
Cecil | |
| 20h. (State)
Md. | | 20i. (Country)
USA | |
| 21. I certify that I attended the deceased from January 26, 1956 , to July 23, 1956 , and that death occurred at 9:32 P.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE
W. Oppler | | ADDRESS (Street, city or town, state)
V.A. Hospital, Perry Point, Md. | |
| PHYSICIAN'S NAME (Type)
W. OPPLER | | DATE SIGNED
7-25-56 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Removal | | 22b. DATE THEREOF
7-24-56 | 22c. NAME OF CEMETERY OR CREMATORY
Arlington National |
| 22d. LOCATION (City, town, or county)
Arlington, Va. | | (State)
Va. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Pennington & Son, Havre de Grace, Md. | | 24a. REC'D BY REGISTRAR
7-25-56 | |
| 24b. REGISTRAR'S SIGNATURE
Isaac E. Laugherty | | 24c. (City, town, or county)
Baltimore, Md. | |

BUREAU V.

RECEIVED

7139
CERTIFICATE OF DEATH

Reg. Dist. No. 96

| | | | | | | | |
|--|--|---|--|---|--|--|---|
| 1. PLACE OF DEATH
a. COUNTY Cecil MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Cecil | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Perry Point | | | | c. LENGTH OF STAY IN 1b
11yrs.3mo.18days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address)
Veterans Administration Hospital | | | | d. STREET ADDRESS
R.D. 4 | | | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print)
First JOSEPH Middle B. Last MULLEN | | | | 4. DATE OF DEATH
Month July Day 23 Year 1956 | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
2-7-91 | |
| 9. AGE (In years last birthday)
65 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Laborer | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Farm | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | | | | | | |
| 13. FATHER'S NAME
Dennis Mullen | | | | 14. MOTHER'S MAIDEN NAME
Unknown | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) Yes <input checked="" type="checkbox"/> (If yes, give war or dates of service) WW I | | | | 16. SOCIAL SECURITY NO.
unknown | | 17. INFORMANT
Hospital Records, VAH, Perry Point, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial infarction
420.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Secondary with congestive failure
DUE TO
(c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
Unknown
3 days |
| 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. VA 19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | | | 20g. (County) | | 20h. (State) | |
| 21. I certify that I attended the deceased from April 5 , 19 45 , to July 23 , 19 56 , and that death occurred at 8:10 a.m. from the causes and on the date stated above.
ADDRESS (Street, city or town, state) V.A. Hospital, Perry Point, Md. DATE SIGNED 7-23-56
ACTUAL SIGNATURE W. Oppler M.D.
PHYSICIAN'S NAME (Type) W. OPPLER Director, Professional Services | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Removal | | 22b. DATE THEREOF
7-23-56 | | 22c. NAME OF CEMETERY OR CREMATORY
unknown | | 22d. LOCATION (City, town, or county) (State)
Elkton, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Bennington's Son, Harry de Grace, Md. | | | | 24a. REC'D BY REGISTRAR
DATE 7-23-56 | | 24b. REGISTRAR'S SIGNATURE
Irma E. Langharty | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | | | | | | | | | | | | | | | | | | | | | |
|------------------|--|----------------|--|--------------------|--|--------------------------|--|-----------------------------|--|-----------------------------|--|-----------------------------|--|-----------------------------|--|-----------------------------|--|-----------------------------|--|-----------------------------|--|-----------------------------|--|
| Name of Deceased | | Sex | | Age | | Date of Birth | | Place of Birth | | Usual Residence | | Cause of Death | | Date of Death | | Time of Death | | Place of Death | | Signature of Physician | | Signature of Registrar | |
| John Doe | | Male | | 45 | | Jan 1, 1910 | | New York City | | New York City | | Heart Disease | | Jan 15, 1956 | | 10:30 AM | | Home | | J. Doe, M.D. | | J. Doe, M.D. | |
| Occupation | | Marital Status | | Previous Illnesses | | Date of Last Examination | | Date of Last Medical Advice | | Date of Last Medical Advice | | Date of Last Medical Advice | | Date of Last Medical Advice | | Date of Last Medical Advice | | Date of Last Medical Advice | | Date of Last Medical Advice | | Date of Last Medical Advice | |
| Teacher | | Married | | None | | Jan 1, 1955 | | Jan 1, 1955 | | Jan 1, 1955 | | Jan 1, 1955 | | Jan 1, 1955 | | Jan 1, 1955 | | Jan 1, 1955 | | Jan 1, 1955 | | Jan 1, 1955 | |
| Date of Death | | Time of Death | | Place of Death | | Signature of Physician | | Signature of Registrar | | Date of Death | | Time of Death | | Place of Death | | Signature of Physician | | Signature of Registrar | | Date of Death | | Time of Death | |
| Jan 15, 1956 | | 10:30 AM | | Home | | J. Doe, M.D. | | J. Doe, M.D. | | Jan 15, 1956 | | 10:30 AM | | Home | | J. Doe, M.D. | | J. Doe, M.D. | | Jan 15, 1956 | | 10:30 AM | |

BUREAU V. B.

JUL 25 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07110

7122

CERTIFICATE OF DEATH

Reg. Dist. No.

92

| | | | |
|--|-------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>CECIL</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission)
a. STATE <u>MD</u> b. COUNTY <u>CECIL</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>CECILTON</u> | | c. LENGTH OF STAY IN 1b | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>Union Hospital</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>EARLEVILLE</u> | |
| | | d. STREET ADDRESS | |
| 3. NAME OF DECEASED (Type or print)
First <u>JAMES</u> Middle <u>A.</u> Last <u>NEWCOMB</u> | | 4. DATE OF DEATH
Month <u>JULY</u> Day <u>14</u> Year <u>1956</u> | |
| 5. SEX
<u>M.</u> | 6. COLOR OR RACE
<u>W.</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>Oct. 30, 1909</u> |
| 9. AGE (In years, lost birthday) <u>46</u> yrs. | | 10. IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>CARPENTER</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>CONTRACTOR & BLDG.</u> | |
| 11. BIRTHPLACE (State or foreign country)
<u>MD.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U. S. A.</u> | |
| 13. FATHER'S NAME
<u>STEPHEN L. NEWCOMB</u> | | 14. MOTHER'S MAIDEN NAME
<u>ELIZABETH WILLSON</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
<u>219-18-9068</u> | |
| 17. INFORMANT
<u>MRS. ELIZABETH NEWCOMB</u> | | Address
<u>EARLEVILLE MD</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Malnutrition</u>
<u>163X</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pulmonary Carcinoma</u>
DUE TO (c) <u> </u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>3 months</u>
<u>7 mos</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. <u> </u> p. m. <u> </u> 19 <u> </u> | | 20d. INJURY OCCURRED
White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Dec</u> , 19 <u>56</u> , to <u>14 July</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>14 July</u> , 19 <u>56</u> , and that death occurred at <u>12:30 PM</u> from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED
ACTUAL SIGNATURE <u>Wallace Obenshain</u> M.D. <u>Cecilton, Md.</u> <u>16 Jul 56</u>
PHYSICIAN'S NAME (Type) <u>Wallace Obenshain, M.D.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | | 22b. DATE THEREOF
<u>7/17/56</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY
<u>GALENA CEM.</u> | | 22d. LOCATION (City, town, or county) (State)
<u>GALENA MD.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Edward Fellows</u> | | 24a. REC'D BY REGISTRAR
<u>JUL 18 1956</u> | |
| ADDRESS
<u>Mellington, Md.</u> | | 24b. REGISTRAR'S SIGNATURE
<u>F. R. FRAZIER</u> | |

CERTIFICATE OF DEATH

| | | | |
|---|--|---|--|
| <p>1. NAME OF DECEASED
 [Faint text]</p> | | <p>2. SEX
 [Faint text]</p> | |
| <p>3. AGE
 [Faint text]</p> | | <p>4. DATE OF BIRTH
 [Faint text]</p> | |
| <p>5. PLACE OF BIRTH
 [Faint text]</p> | | <p>6. OCCUPATION
 [Faint text]</p> | |
| <p>7. MARITAL STATUS
 [Faint text]</p> | | <p>8. CAUSE OF DEATH
 [Faint text]</p> | |
| <p>9. DATE OF DEATH
 [Faint text]</p> | | <p>10. TIME OF DEATH
 [Faint text]</p> | |
| <p>11. PLACE OF DEATH
 [Faint text]</p> | | <p>12. SIGNATURE OF DECEASED
 [Faint text]</p> | |
| <p>13. SIGNATURE OF WITNESS
 [Faint text]</p> | | <p>14. SIGNATURE OF PHYSICIAN
 [Faint text]</p> | |
| <p>15. SIGNATURE OF CORONER
 [Faint text]</p> | | <p>16. SIGNATURE OF JURY
 [Faint text]</p> | |
| <p>17. SIGNATURE OF JURY
 [Faint text]</p> | | <p>18. SIGNATURE OF JURY
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| <p>19. SIGNATURE OF JURY
 [Faint text]</p> | | <p>20. SIGNATURE OF JURY
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| <p>21. SIGNATURE OF JURY
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| <p>23. SIGNATURE OF JURY
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| <p>29. SIGNATURE OF JURY
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| <p>31. SIGNATURE OF JURY
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| <p>33. SIGNATURE OF JURY
 [Faint text]</p> | | <p>34. SIGNATURE OF JURY
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| <p>35. SIGNATURE OF JURY
 [Faint text]</p> | | <p>36. SIGNATURE OF JURY
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| <p>37. SIGNATURE OF JURY
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| <p>45. SIGNATURE OF JURY
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| <p>81. SIGNATURE OF JURY
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| <p>97. SIGNATURE OF JURY
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 [Faint text]</p> | |
| <p>99. SIGNATURE OF JURY
 [Faint text]</p> | | <p>100. SIGNATURE OF JURY
 [Faint text]</p> | |

BUREAU V. 8

JUL 18 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7140

CERTIFICATE OF DEATH

Reg. Dist. No.

07111

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Cecil MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland b. COUNTY Cecil | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cherry Hill | | | | c. LENGTH OF STAY IN 1b | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cherry Hill, Maryland | | | |
| | | | | d. STREET ADDRESS | | | |
| | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First Mary Middle Emma Last Nowland | | | | 4. DATE OF DEATH
Month July Day 20 Year 19 56 | | | |
| 5. SEX
Female | | 6. COLOR OR RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
Sept. 5, 1881 | |
| | | | | 9. AGE (In years last birthday)
74 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
Home | | 11. BIRTHPLACE (State or foreign country)
Cecil County | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Robert Scott. | | | | 14. MOTHER'S MAIDEN NAME
EMMA YATES | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
no | | 16. SOCIAL SECURITY NO.
(If yes, give war or dates of service) | | 17. INFORMANT
Edwin G. Nowland. Address Elkton, Md. 203 | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 422.2 Leukemic myocardiitis DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO
(c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
5 yrs |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
None | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
None | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from July 14, 1956 , to July 21, 1956 , that I last saw the deceased alive on July 20, 1956 , and that death occurred at 8:30 P.M. , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) 202 East Main Street, Elkton, Md. DATE SIGNED 7/23/56
ACTUAL SIGNATURE Jacob Greenwald
PHYSICIAN'S NAME (Type) Dr. Jacob Greenwald | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
7/24/56 | | 22c. NAME OF CEMETERY OR CREMATORY
Bethel | | 22d. LOCATION (City, town, or county) (State)
nr. Chesapeake City, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Harry Tappin | | | | ADDRESS
Elkton, Maryland | | 24a. REC'D BY REGISTRAR
DATE 7/27/56 | |
| | | | | 24b. REGISTRAR'S SIGNATURE
FR Frazier | | | |

RECEIVED

JUL 31 1956

BUREAU V. 5

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07112

7123

CERTIFICATE OF DEATH

Reg. Dist. No. 97

| | | | | | | | |
|---|------------------------|--|--------------------------------|---|------------------------------|--|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY Cecil | | MARYLAND | | STATE Maryland | | COUNTY Cecil | |
| CITY (If outside corporate limits, write RURAL and give nearest town) Elkton | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) Chesapeake City | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS Union Hospital | | | | STREET ADDRESS (If rural give location) | | | |
| 3. NAME OF DECEASED (Type or Print) (First) Howard (Middle) (Last) Park | | | | 4. DATE OF DEATH (Month) July (Day) 28 (Year) 1956 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widower | 8. DATE OF BIRTH Nov. 25, 1886 | 9. AGE last birthday 69 yrs. | 10. UNDER 1 YEAR Months Days | 11. UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer | | 10b. KIND OF BUSINESS OR INDUSTRY Tenant | | 11. BIRTHPLACE (State or foreign country) Carlisle - Maryland | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | |
| 13. FATHER'S NAME George Park | | | | 14. MOTHER'S MAIDEN NAME ? | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) | | 16. SOCIAL SECURITY NO. Lost | | 17. INFORMANT & ADDRESS Mrs. Margaret White - daughter | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | 18. MEDICAL CERTIFICATION | | | |
| 331X IMMEDIATE CAUSE (A) | | | | Cerebral Hemorrhage | | | |
| ANTECEDENT CAUSE(S) DUE TO | | | | Arteriosclerosis | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE | | | | | | | |
| STATING UNDERLYING CAUSE LAST. DUE TO (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from July 25, 1956, to July 28, 1956, that I last saw the deceased alive on July 28, 1956, and that death occurred at 6:30 P.M. from the causes and on the date stated above. | | | | | | | |
| SIGNATURE V. H. Meyer, M.D. | | | | ADDRESS Elkton - Maryland | | DATE SIGNED 7-28-56 | |
| 23. BURIAL, CREMATION, REMOVAL (Specify) Burial | | DATE THEREOF July 31 | | NAME OF CEMETERY OR CREMATORY Bethel Cem. | | LOCATION (City, town, or county) Chesapeake City Md. | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE F. R. Langer | | 25. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS Edward E. Blair Mulling, Md. | |
| DATE AUG 3 1956 | | | | | | | |

CERTIFICATE OF DEATH

Form 10-1-54

UNITED STATES DEPARTMENT OF HEALTH

MARYLAND

COUNTY OF BALTIMORE

CITY OF BALTIMORE

WARD OF BALTIMORE

STREET OF BALTIMORE

APARTMENT OF BALTIMORE

ROOM OF BALTIMORE

ZIP CODE OF BALTIMORE

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

Cause of Death

Immediate Cause

Underlying Cause

Contributing Cause

Manner of Death

Medical Certification

Signature of Physician

Signature of Coroner

Signature of Registrar

Signature of Burial Officer

Signature of Witness

Signature of Family

Signature of Neighbor

Signature of Minister

Signature of Priest

Signature of Rabbi

Signature of Imam

Signature of Other

Signature of Other

Signature of Other

Signature of Other

Signature of Other

Signature of Other

Signature of Other

Signature of Other

Signature of Other

Signature of Other

Signature of Other

Signature of Other

Signature of Other

Signature of Other

BUREAU V. 2

AUG 3 1956

RECEIVED

2.11.1956

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

7124

Reg. Dist. No. 92

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH
COUNTY <u>Cecil</u> MARYLAND
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Elkton</u> LENGTH OF STAY (in this place) <u>—</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Union Hospital</u> | | 2. USUAL RESIDENCE (HOME) OF DECEASED
STATE <u>Md</u> COUNTY <u>Cecil</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Charlestown</u> STREET ADDRESS (If rural give location) <u>—</u> | |
| 3. NAME OF DECEASED (Type or Print) <u>Baby Michael Vance Presnell</u> (First) (Middle) (Last)
4. DATE OF DEATH <u>7-28</u> 19 <u>56</u> (Month) (Day) (Year) | | 5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u> 8. DATE OF BIRTH <u>7-28-1956</u> 9. AGE last birthday <u>2</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. <u>2</u> <u>30</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u> 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13. FATHER'S NAME <u>Serdine Presnell</u> 14. MOTHER'S MAIDEN NAME <u>Helen Taylor</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service) 16. SOCIAL SECURITY NO. <u>—</u> 17. INFORMANT & ADDRESS <u>Serdine Presnell, Charlestown Md</u> | | 18. MEDICAL CERTIFICATION
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH
IMMEDIATE CAUSE (A) <u>Congenital Heart Disease-type undetermined</u>
ANTECEDENT CAUSE(S) DUE TO <u>—</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>—</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>—</u>
19a. DATE OF OPERATION <u>—</u> 19b. MAJOR FINDINGS OF OPERATION <u>—</u> 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>—</u> 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>—</u> | | 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 21f. HOW DID INJURY OCCUR? <u>—</u> | |
| 22. I hereby certify that I attended the deceased from <u>28 July</u> , 19 <u>56</u> , to <u>28 July</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>28 July</u> , 19 <u>56</u> , and that death occurred at <u>6:10 AM</u> , from the causes and on the date stated above.
SIGNATURE <u>Klaus H. Thuehner</u> M.D. ADDRESS (Street, city, town, state) <u>North East Md</u> DATE SIGNED <u>28 July '56</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> DATE THEREOF <u>7-28-1956</u> NAME OF CEMETERY OR CREMATORY <u>Principio</u> LOCATION (City, town, or county) (State) <u>Principio Turnace, Md</u> | | 24. REC'D BY REGISTRAR <u>7/28/56</u> REGISTRAR'S SIGNATURE <u>J R Trazu</u> 25. FUNERAL DIRECTOR'S SIGNATURE <u>See A. Patterson Son, Perryville, Md</u> ADDRESS <u>—</u> | |

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

07114

Reg. Dist. No.....

7141

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY Cecil | | MARYLAND | | STATE Md. | | COUNTY Cecil | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| OR TOWN Rising Sun, Rural | | 24 days | | OR TOWN Colora, Rural | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS Graybeal Convalescent Home | | | | STREET ADDRESS (If rural give location) | | | |
| 3. NAME OF DECEASED (Type or Print) Mary Ellen Lent Reynolds | | | | 4. DATE OF DEATH July 21 1956 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Divorced | | 8. DATE OF BIRTH Jan. 4, 1898 | |
| | | | | 9. AGE last birthday 58 yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Bookkeeper | | 10b. KIND OF BUSINESS OR INDUSTRY Office Management | | 11. BIRTHPLACE (State or foreign country) Yonkers N.Y. | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME William Henry Lent | | | | 14. MOTHER'S MAIDEN NAME Mary Ellen Dixon | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no | | 16. SOCIAL SECURITY NO. 131-03-6495 | | 17. INFORMANT & ADDRESS Mrs. Carol Onderdonk Colora, Md. | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | 18. MEDICAL CERTIFICATION | | | |
| 170X IMMEDIATE CAUSE (A) Cardiac Decompensation | | | | INTERVAL BETWEEN ONSET AND DEATH 3 days | | | |
| ANTECEDENT CAUSE(S) DUE TO Alveolitis | | | | 2 wks | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO metastases of Breast Ca | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION Carcinoma rt breast | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from 7/5 1956 to 7/21 1956 that I last saw the deceased alive on 7/20 1956, and that death occurred at 8:00 A.M. from the causes and on the date stated above. | | | | | | | |
| SIGNATURE [Signature] | | | | ADDRESS (Street, city, town, state) Rising Sun, Md. | | DATE SIGNED 7/23/56 | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | DATE THEREOF July 24, 1956 | | NAME OF CEMETERY OR CREMATORY West Nottingham | | LOCATION (City, town, or county) Near Colora Md. | |
| 24. REC'D BY REGISTRAR [Signature] | | REGISTRAR'S SIGNATURE [Signature] | | 25. FUNERAL DIRECTOR'S SIGNATURE [Signature] | | ADDRESS [Address] | |

CERTIFICATE OF DEATH

1. NAME OF DECEASED: *John Doe*

2. SEX: *Male*

3. AGE: *45*

4. DATE OF BIRTH: *Jan 15 1910*

5. PLACE OF BIRTH: *Baltimore, Md*

6. OCCUPATION: *Teacher*

7. CAUSE OF DEATH: *Heart Disease*

8. DATE OF DEATH: *Jul 25 1956*

9. PLACE OF DEATH: *Home*

10. SIGNATURE OF PHYSICIAN: *[Signature]*

11. SIGNATURE OF REGISTRAR: *[Signature]*

John Doe
Teacher
Baltimore, Md

BUREAU V. S.

JUL 25 1956

RECEIVED

INSTRUCTIONS

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07115

CERTIFICATE OF DEATH

Reg. Dist. No. 96

7142

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY Cecil | | MARYLAND | | STATE Md. | | COUNTY Cecil | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| TOWN Rising Sun Rural | | 1 yr. | | TOWN Rising Sun Rural | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | | | STREET ADDRESS (If rural give location) | | | |
| 3. NAME OF DECEASED (Type or Print) | | | | 4. DATE OF DEATH | | | |
| (First) Mike | | (Middle) Shmel | | (Last) | | (Year) 1956 | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married | | 8. DATE OF BIRTH June 27 1891 | |
| | | | | 9. AGE last birthday 65 yrs. | | 10. IF UNDER 1 YEAR Months Days | |
| | | | | | | 11. IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinest | | 10b. KIND OF BUSINESS OR INDUSTRY Steel Mill | | 11. BIRTHPLACE (State or foreign country) Russia | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME Demitrie Shmel | | | | 14. MOTHER'S MAIDEN NAME Unknown | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS Mrs. Pauline Shmel Rising Sun, Md. | | | |
| | | | | | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | 18. MEDICAL CERTIFICATION | |
| 153X IMMEDIATE CAUSE (A) Carcinoma Pigmentosa | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSE(S) DUE TO Genital Carcinomatosis | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO Cerebrum | | | | | | | |
| STATING UNDERLYING CAUSE LAST. (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from 2/10, 1954 to 7/26, 1956, that I last saw the deceased alive on 7/26, 1956, and that death occurred at 3:30 P.M. from the causes and on the date stated above. | | | | | | | |
| SIGNATURE | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) | |
| Charles J. Foley | | July 30, 1956 | | Hartford | | Conn. | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | REGISTRAR'S SIGNATURE | | 24. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | |
| Burial | | Innocent E. Longley | | J. Earl Tyson | | Rising Sun, Md. | |
| DATE 7/30/1956 | | | | | | | |

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH - BATHING

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. SIGNATURE OF PHYSICIAN

9. SIGNATURE OF REGISTRAR

10. SIGNATURE OF WITNESSES

11. SIGNATURE OF DECEASED

12. SIGNATURE OF BURIAL

13. SIGNATURE OF INTERMENT

14. SIGNATURE OF RECORD

15. SIGNATURE OF OFFICE

16. SIGNATURE OF DEPARTMENT

BUREAU V. 1

AUG 2 1956

RECEIVED

Handwritten notes at the bottom of the page.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07116 *g2*
Reg. Dist. No.

| | | | | | | | |
|---|--|---|---|---|---|--|---|
| 1. PLACE OF DEATH
a. COUNTY Cecil 7125 | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. b. COUNTY Cecil | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Elkton | | | c. LENGTH OF STAY IN 1b
2 hours | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Port Deposit | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Union Hospital | | | | d. STREET ADDRESS
247 Laffey Circle | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)
First George Middle McCloud Last Thompson, Jr. | | | | 4. DATE OF DEATH
Month 7 Day 8 Year 1956 | | | |
| 5. SEX
M | | 6. COLOR OR RACE
W | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
Feb. 2, 1955 | |
| 9. AGE (In years last birthday)
1 yrs. | | IF UNDER 1 YEAR
Months 19 Days Hours Min. | | IF UNDER 24 HRS.
Hours Min. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Infant | | | | 10b. KIND OF BUSINESS OR INDUSTRY
 | | 11. BIRTHPLACE (State or foreign country)
Easton, Md. | |
| 13. FATHER'S NAME
George McCloud Thompson, Sr. | | | | 14. MOTHER'S MAIDEN NAME
Minnie Lowm | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
no | | 16. SOCIAL SECURITY NO.
 | | 17. INFORMANT Address
U.S. Navy, Bainbridge. Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Fractured Skull and crushed chest.
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)
DUE TO (c) | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Was in car and the car was hit by another | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
12:20 A.M. 7 8 56 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/>
at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Route 40 | | 20f. (City or town) (County) (State)
Elkton Cecil Md. | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE <i>R.C. Dodson</i> | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) R.C. Dodson | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | DATE SIGNED 7-8-56 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
July 12, 1956 | | 22c. NAME OF CEMETERY OR CREMATORY
Mt Pisgah, La. | | 22d. LOCATION (City, town, or county) (State)
Franklinton, La. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<i>W. Henry Phipps</i>
2596 Main St. Elkton Md. | | | | 24a. REC'D BY REGISTRAR
DATE 7/11/56 | | 24b. REGISTRAR'S SIGNATURE
<i>J.R. Frazer</i> | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your information. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

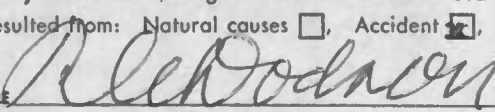
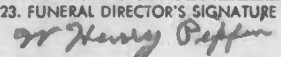
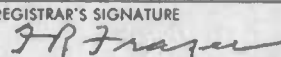
| | | | | | |
|-------------------------------|--|--------------------------|--|------------------------|--|
| Name of Deceased | | Age | | Sex | |
| Place of Birth | | Date of Birth | | Date of Death | |
| Cause of Death | | Manner of Death | | Place of Death | |
| Signature of Medical Examiner | | Signature of Coroner | | Signature of Registrar | |
| Date of Examination | | Date of Coroner's Report | | Date of Registration | |

BUREAU V. 1
JUL 13 1956
RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07117
92
Reg. Dist. No.

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| 1. PLACE OF DEATH
a. COUNTY Cecil MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE Md. b. COUNTY Cecil | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Elkton, R.D. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Port Deposit | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Route 40 | | e. STREET ADDRESS
247 Laffey Circle | |
| 3. NAME OF DECEASED
First Kathy Middle Lynn Last Thompson
(Type or print) | | | |
| 5. SEX F | | 6. COLOR OR RACE W | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
Sept. 6, 1947 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Child | | 10b. KIND OF BUSINESS OR INDUSTRY
Texas | |
| 11. BIRTHPLACE (State or foreign country)
Texas | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
George McCloud Thompson | | 14. MOTHER'S MAIDEN NAME
Minnie Low | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
no | | 16. SOCIAL SECURITY NO.
Naval Record, Bainbridge, Md. | |
| 17. INFORMANT
Naval Record, Bainbridge, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Fractured skull and face.
816X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO
(c) _____ | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Was in car and hit by another | |
| 20c. TIME OF INJURY
Month, Day, Year
12-30-56
a. m. 7 b. p. 8 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Route 40 | | 20f. (City or town) (County) (State)
Elkton Cecil Md. | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE

EXAMINER'S NAME (Type) R.C. Dodson | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Removal | | 22b. DATE THEREOF
7-12-56 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Mt. Pisgah | | 22d. LOCATION (City, town, or county) (State)
Franklinton, La. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
 | | 24a. REC'D BY REGISTRAR
DATE 7/11/56 | |
| 24b. REGISTRAR'S SIGNATURE
 | | DATE SIGNED
7-8-56 | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

2000-2001

7126

CERTIFICATE OF DEATH

Reg. Dist. No. 92

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| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY Cecil | | MARYLAND | | STATE Maryland | | COUNTY Cecil | |
| CITY (If outside corporate limits, write RURAL and give nearest town)
TOWN Elkton | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town)
TOWN Elkton | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS
129 Hollingsworth Manor | | | | STREET ADDRESS (If rural give location)
129 Hollingsworth Manor | | | |
| 3. NAME OF DECEASED
(Type or Print) Addie Lillian Turman | | | | 4. DATE OF DEATH (Month) (Day) (Year)
July 12 1956 | | | |
| 5. SEX
F | 6. COLOR OR RACE
Wh. | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married | 8. DATE OF BIRTH
Jan 30, 1894 | 9. AGE last birthday
62 yrs. | IF UNDER 1 YEAR
Months Days | | IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
House Wife | | 10b. KIND OF BUSINESS OR INDUSTRY
At Home | | 11. BIRTHPLACE (State or foreign country)
va. | | 12. CITIZEN OF WHAT COUNTRY?
U S A | |
| 13. FATHER'S NAME
Marrion Dalton | | | | 14. MOTHER'S MAIDEN NAME
Delia Phillips | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)
(If Yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
220-14-9787 | | 17. INFORMANT & ADDRESS
Quentin E. Turman 129 Hollingsworth Manor Elkton, Md. | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | 18. MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH | |
| 196X IMMEDIATE CAUSE (A) Congestive Heart Failure | | | | | | 10 days | |
| ANTECEDENT CAUSE(S) DUE TO | | | | Osteogenic Sarcoma generalized (metastases) | | 5 yrs | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) | | | | | | | |
| 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>Free</u> , 19 <u>55</u> , to <u>12 July</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>11 July</u> , 19 <u>56</u> , and that death occurred at <u>6:30 PM</u> , from the cause and on the date stated above. | | | | | | | |
| SIGNATURE <u>George J. Pinner</u> M.D. | | | | ADDRESS (Street, city, town, state) <u>Elkton, Md.</u> | | DATE SIGNED <u>7/13/56</u> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | DATE HEREOF
July 14, 1956 | | NAME OF CEMETERY OR CREMATORY
Gilpin Manor Memo. Pk. | | LOCATION (City, town, or county) (State)
R. D. Elkton, Md. | |
| 24. REC'D BY REGISTRAR
DATE <u>7/14/56</u> | | REGISTRAR'S SIGNATURE
<u>J. H. Frazer</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE
<u>W. Henry Piffin</u> | | ADDRESS
<u>Elkton Md. W. A. R.</u> | |

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 17

DATE OF DEATH

PLACE HERE NAME OF DECEASED

NAME OF DECEASED

DATE OF DEATH

PLACE HERE NAME OF DECEASED

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DATE OF DEATH

BUREAU V. 8

JUL 17 1956

RECEIVED

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

07119
96

7144

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| 1. PLACE OF DEATH
a. COUNTY Cecil MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point | | c. LENGTH OF STAY IN 1b 12yrs. 6 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital | | d. STREET ADDRESS 2339 Frederick Ave., | |
| 3. NAME OF DECEASED (Type or print) First FREDERICK Middle W. Last VOLLERS | | 4. DATE OF DEATH Month July Day 30 Year 1956 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 2-10-94 |
| 9. AGE (In years last birthday) 62 yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baker | | 10b. KIND OF BUSINESS OR INDUSTRY Bakery | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Frederick W. Vollers | | 14. MOTHER'S MAIDEN NAME Margaret Shaffer | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes <input checked="" type="checkbox"/> WWI | | 16. SOCIAL SECURITY NO. Unknown | |
| 17. INFORMANT Address Hospital Records, VAH, Perry Point, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary thrombosis
420.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | INTERVAL BETWEEN ONSET AND DEATH 30 minutes |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |
| 20f. (City or town) | | (County) (State) | |
| 21. I certify that I attended the deceased from July 24, 1944, to July 30, 1956, and that death occurred at 7:30 A.M. from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED
ACTUAL SIGNATURE W. Oppler M.D. W. Oppler, Chief, Prof. Services
PHYSICIAN'S NAME (Type) W. Oppler | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 22b. DATE THEREOF 7-30-56 | 22c. NAME OF CEMETERY OR CREMATORY London | 22d. LOCATION (City, town, or county) Frederick Co. Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 5646 Carville Ave, Balt. | | 24a. REC'D BY REGISTRAR DATE 7/30-56 | 24b. REGISTRAR'S SIGNATURE Irene E. Hughes |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

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| 1. NAME OF DECEASED | | 2. SEX | | 3. AGE | | 4. RACE | | 5. DATE OF BIRTH | | 6. PLACE OF BIRTH | | 7. DATE OF DEATH | | 8. PLACE OF DEATH | | 9. CAUSE OF DEATH | | 10. MANNER OF DEATH | | 11. SIGNATURE OF PHYSICIAN | | 12. SIGNATURE OF REGISTRAR | |
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **0712076**

| | | | |
|---|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY Cecil 7145 MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Pa. b. COUNTY Lancaster | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Port Deposit | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Lancaster 75 X-3 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Port Deposit | | d. STREET ADDRESS
438 Chamber | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First John Middle M. Last White | | 4. DATE OF DEATH
Month 7 Day 3 Year 19 56 | |
| 5. SEX M | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
7-30-1924 |
| 9. AGE (In years last birthday)
31 yrs. | | IF UNDER 1 YEAR
Months 11 Days | IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Moulder | | 10b. KIND OF BUSINESS OR INDUSTRY
Casting Co. | |
| 11. BIRTHPLACE (State or foreign country)
Lancaster | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
William M. White | | 14. MOTHER'S MAIDEN NAME
Kautz | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
yes | | 16. SOCIAL SECURITY NO.
W.W.2 | |
| 17. INFORMANT
Wm. White, Lancaster, Pa. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Drowned
DUE TO
Conditions, if any, which gave rise to immediate cause (b)
(c), stating the underlying cause lost. DUE TO | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Tried to swim shore after jumping out of boat Susquehanna River | |
| 20c. TIME OF INJURY
Hour 7:30 a. m. 7-3-56 p. m. | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
River | 20f. (City or town) (County) (State)
Port Deposit Cecil Md. |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE
R.C. Dodson | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type)
R.C. Dodson | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
7-7-56 | |
| 22c. NAME OF CEMETERY OR CREMATORY
St. Mary's | | 22d. LOCATION (City, town, or county) (State)
Lancaster Pa. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Lee A. Patterson & Son, Perryville, Md. | | 24a. REC'D BY REGISTRAR
DATE 7-7-56 | |
| | | 24b. REGISTRAR'S SIGNATURE
Inema E. Langley | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please note the date and time, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

1956 OCT 10

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07121

Reg. Dist. No.

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY Cecil 7146
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Liberty Grove
c. LENGTH OF STAY IN 1b 20 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. b. COUNTY Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Liberty Grove
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Rose Caldwell Woodrow
First Middle Last | | 4. DATE OF DEATH
Month 7 Day 29 Year 1956 | |
| 5. SEX F. | 6. COLOR OR RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 11-6-1884 |
| 9. AGE (In years last birthday) 71 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | 11. IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife | | 10b. KIND OF BUSINESS OR INDUSTRY Keeping house | |
| 11. BIRTHPLACE (State or foreign country) Rowlandville, Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Washington Caldwell | | 14. MOTHER'S MAIDEN NAME Margaret Kell Bird | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no
(If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 212-14-37008 | |
| 17. INFORMANT Margaret Kell, Liberty Grove, Md.
Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 420.1 Acute Coronary Thrombosis
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
INTERVAL BETWEEN ONSET AND DEATH | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m. 19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE R.C. Dodson
EXAMINER'S NAME (Type) R.C. Dodson, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 7-29-56 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | 22b. DATE THEREOF Aug 1, 1956 | 22c. NAME OF CEMETERY OR CREMATORY Harmony Chapel | 22d. LOCATION (City, town, or county) (State) Rowlandville Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE J. Earl Tyson
ADDRESS Rising Sun Md. | | 24. REC'D BY REGISTRAR 30-56
DATE
24b. REGISTRAR'S SIGNATURE L.M. Northington | |

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MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination and death certification, including fields for name, age, sex, race, and cause of death. The form is mostly blank with some faint markings.

BUREAU V. 3

AUG 2 1956

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